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MARGIN RESERVED FOR BINDING  
N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PLACE OF DEATH

1. County \_\_\_\_\_  
District \_\_\_\_\_  
Town or City \_\_\_\_\_

## ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

## ORIGINAL CERTIFICATE OF DEATH

State Index - - - No. 73  
County Registrar's - No. 320  
Local Registrar's - No. \_\_\_\_\_

2. FULL NAME Thomas Gilbert DePriest  
(If death occurred in a hospital or institution, give its NAME instead of street number)

(a) Residence. No. 47 Upper Lowell St. 16 Ward. 16  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR or RACE American 5. SINGLE, MARRIED, WIDOWED or DIVORCED Divorced  
(Write the word)

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5-4-1883

7. AGE Years Months Days IF LESS than  
41 1 25 1 day... hrs. or... min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill Operator  
(b) General nature of industry, business or establishment in which employed (or employer) Mexican Boss  
(c) Name of employer P.O. Co.

9. BIRTHPLACE (city or town) Silver City  
(State or country) New Mex.

10. NAME OF FATHER A A DePriest

11. BIRTHPLACE OF FATHER Fayetteville  
(State or country) Arkansas

12. MAIDEN NAME OF MOTHER Bernella DePriest

13. BIRTHPLACE OF MOTHER De Moines  
(State or country) Iowa

14. Informant (Address) \_\_\_\_\_

15. Filed 6/30 1924 C. F. Hawley M.D. Local Registrar.

Filed 7-7-24 19 R B Lumb County Registrar.  
V. S. No. 1

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) June 29, 1924

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1924 to June 29, 1924

that I last saw him alive on June 29, 1924

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH\* was as follows:  
Fractured Skull.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Grain G. Bridges, M. D. (Address) Barber Ariz.

\* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL Barber, Arizona DATE OF BURIAL July 2, 1924

20. UNDERTAKER Barber, Arizona ADDRESS \_\_\_\_\_